

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015500

STATE FILE NUMBER

2 3330

FILED APR 27 1959

Registration District No. Primary Registration District No.

Registration No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kirkwood 4651</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp.</u>		Length of stay in 1b <u>#1</u>	d. STREET ADDRESS (If outside, give location) <u>10341 Manchester Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>O'</u> Last <u>Crowley</u>			4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1877</u>		9. AGE (In years) FUNDERS 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>3</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Springfield, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Daniel O'Crowley</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Kavanaugh</u>	
14. NAME OF HUSBAND OR WIFE <u>-----</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>498-07-4540A</u>	
17. INFORMANT Address <u>Miriam Johnson, Minneapolis, Minn.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>332X</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>March 4, 1959</u> to <u>April 2, 1959</u> and last saw her/him alive on <u>April 2, 1959</u> . Death occurred at <u>1:40</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert E. Stuppelbaum M.D.</u>		22b. ADDRESS <u>1515 Lafayette Ave.</u>		22c. DATE SIGNED <u>4/2/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Apr. 4, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Springfield, Illinois.</u>		23e. STATE <u>Illinois</u>			
24. FUNERAL DIRECTOR ADDRESS <u>A. H. Bocklage 6536 Clayton Rd.</u>		25. DATE RECD. BY LOCAL REG. <u>APR 3 '59</u>		26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

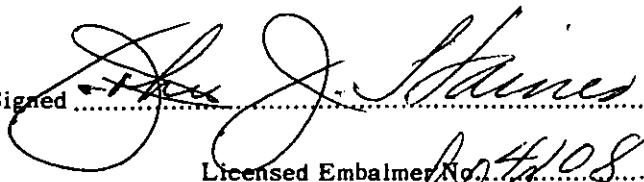

All diseases in Part I must be causally related.

m2B

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 4108
P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.